DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/01/17 / 70th 9/26/17

07/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445351	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF GREENEVILLE	106 HOLT COURT GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 7/16/2017. During this Life Safety Survey, Signature Healthcare of Greeneville was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire resistance of smoke barriers per the requirements above and: 2012 NFPA 101 Section 8.3.5.1.	K 372	**K 372 NFPA 101 Subdivision of Building Spaces** The two penetration at the annular space have been corrected and fire stopped on 8/11/17. The penetration above panel EW has been fire stopped on 8/11/17 The opening in the gypsum above the ATS panel has been repaired on 8/11/17. A 100% audit of facility for penetrations was conducted by the maintenance supervisor was conducted on 8/11/17. Findings from audit will be reviewed with the administrator and then corrected. Education was provided to the maintenance director by the administrator on 8/8/17 on penetrations. The maintenance supervisor will audit 10 areas of facility for penetrations for 4 weeks and then monthly for 2 months or until penetrations are resolved. Audits will be reviewed at the monthly QAPI meeting, if any deficient practices are noted in the morning white board meeting or monthly audits the deficient practice will be immediately corrected and reported to the monthly QA meeting for 3 months beginning August 2017.	8/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Adm 8/9/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 372	Continued From page 1 2012 NFPA 101 Section 19.3.7.3, 8.3.5.1, 8.5.6.2, The findings include: 1. Observation with the Maintenance Director, on 7/16/2017 at 10:03 AM revealed the 1-hour fire rated ceiling of the emergency code cart room had metal conduit through the gypsum ceiling above an electrical panel where the firestopping had come out of the annular space resulting in two unsealed penetrations that would not resist the passage of smoke. 2. Observation with the Maintenance Director, on 7/16/2017 at 12:52 PM revealed the 1-hour fire rated ceiling of the main electrical room had metal conduit through the gypsum ceiling above panel "EW" that was not sealed. 3. Observation with the Maintenance Director, on 7/16/2017 at 12:53 PM revealed the 1-hour fire rated ceiling of the main electrical room had electrical wiring through a 6-inch by 3-inch opening in the gypsum ceiling above the ATS panel that was not sealed. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 7/16/2017.	K 372	**K 753 Combustible Decorations** The combustible decoration on all facility doors were removed on 8/11/17 by the maintenance director. A 100% audit of all doors in facility was conducted on combustible materials by the maintenance director on 8/11/17. Any combustible materials will removed immediately by the maintenance director. Education on combustible decorations was provided to the maintenance director by the administrator on 8/8/17. The maintenance director will audit 10 resident care areas for combustible materials weekly times 4 weeks and then monthly for 2 months to ensure combustible materials are removed from facility doors. Audits will be reviewed at the monthly QAPI meeting, if any deficient practices are noted in the morning white board meeting or monthly audits the deficient practice will be immediately corrected and reported to the monthly QA meeting for 3 months beginning August 2017.	8/18/17
K 753 SS=E	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.	K 753		

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K 753	Continued From page 2 * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure combustible decorations were not highly flammable per the requirements of: 2012 NFPA 101 Section 19.7.5.6 This deficiency affected 12 of 94 resident rooms. The findings include: Observation and interview with the Maintenance Director on 7/16/2017 between 9:50 AM and 12:00 PM confirmed the facility failed to show combustible decorations on resident room doors 181, 228, 229, 120, 125, 119, 118, 117, 110, 107, 104, and 101 were fire resistant or treated with a fire retardant material. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 7/16/2017.	K 753	**K 920 Electric equipment – power cords and extensions** The power strips in rooms 105, 106 and therapy gym will be removed by the maintenance director by 8/11/17. A 100% audit will be conducted in all resident care areas of the facility by 8/11/17 to ensure resident care areas have appropriate electrical equipment, power cords, and power strips. Education was provided to the maintenance director on 8/8/17 on appropriate electrical equipment to include power cords and strips. The maintenance director will audit 10 areas for appropriate electrical cords/power cords weekly times 4 weeks and then monthly for 2 months to ensure resident care areas have appropriate electrical equipment, power cords, and power strips. Audits will be reviewed at the monthly QAPI meeting, if any deficient practices are noted in the morning white board meeting or monthly audits the deficient practice will be immediately corrected and reported to the monthly QA meeting for 3 months beginning August 2017.	8/18/17
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920		

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K 920	Continued From page 3 (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to provide power strips in patient care areas for patient-care-related electrical equipment (PRCEE) and non-PRCREE that meet UL 1363A or UL 60601-01 for PCREE and UL 1363 for non-PRCREE per the requirements of: NFPA 99 2012 Edition 10.2.3.6, 10.2.4, NFPA 70 400-8 & 590.3 (D) This deficiency affected 1 of 6 smoke compartments. The census the day of the survey was 106 residents. The findings include: Observation and record review on 7/16/2017between 11:45 AM and 2:40 PM revealed the following areas did not have a UL Listed power strip for PCREE and non-PCREE	K 920		

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K 920	Continued From page 4 items: 1. Resident rooms 105 and 106 had a UL1363 power strip in the patient care vicinity with no UL 1363A or UL 60601-01 listing. 2. Physical therapy room had medical equipment (TENS unit and Vectra Neo unit) plugged into a UL1363 power strip. The maintenance director was present when the deficiency was identified and acknowledged by the administrator during the exit conference on 7/16/2017.	K 920		